PPIP Reflection on Legal, Ethical and Professional issues

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The legal, ethical and professional issues involved in completing a Do Not Attempt Resuscitation order.

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Introduction:

This reflective essay will critically consider the legal, ethical and professional issues involved in completing a Do Not Attempt Resuscitation (DNAR) order. This particular issue has been chosen for discussion because there is increasing pressure on health care professionals to establish end of life wishes and discuss DNAR orders (Myint et al, 2006). I recognise that patients and families views on DNAR orders may differ to that of health care professional which may raise issues if Cardio Pulmonary Resuscitation (CPR) is considered futile (Myint et al, 2006). Furthermore, issues surrounding DNAR and making best interest decisions for a patient exists (Yuen et al, 2011). Therefore, this essay will mainly consider issues relating to medical futility and making best interest decisions in relation to DNAR orders.

This essay will use a case study to reflect on and discuss the issues raised. In order to reflect succinctly and to explore my own emotions, actions and judgement I will use aspects of Johns model of reflection to critique and improve my practice (1995). The decision to select this model was due to it being designed specifically for nursing practice (Leeds beckett university, No Date). It is considered that reflection on practice encourages understanding and analysis in order to improve practice (Nabera and Wyattb 2014).

As a nurse, identifying your own moral views and how they may affect patient care is important, as something you may consider the 'right' thing to do, may conflict with that of your patients, colleagues and profession (Ohio Nurses Association, 2012). Reflecting on education and guidance from colleagues and mentors can help define the consequences of acting on moral views, for yourself and those in your care (Ohio Nurses Association, 2012). Therefore understanding laws, ethics and professional expectations is fundamental to ensuring decisions are

made with deliberation and acknowledgement that people's choices might differ to your own (Ohio Nurses Association, 2012). However, recognising diversity is important as ethics concerning medical issues often differ depending on the scenario (Bell, 2013).

The experience

The experience I will reflect upon involved a service user and his wife being visited by a community matron. I will refer to the service users as Mr. Smith and Mrs. Smith to protect confidentiality. Mr. Smith was being visited by the community matron to help with symptom management due to his advanced COPD. His wife, aged 89, with advanced dementia was also under the care of the community matron. Mrs. Smith was unable to mobilise independently, and had difficulty communicating. After several visits to Mr and Mrs. Smith's, the matron wished to discuss DNAR order to establish their wishes. However, as Mrs. Smith was assessed to lack capacity, the decision was made by Mr. Smith whose wishes were for them both to be resuscitated in the event of cardiac respiratory arrest. This essay will focus on Mr. Smith making the decision on the behalf of his wife.

Prior to visiting Mr and Mrs. Smith, discussions took place about the DNAR process with the matron. It was considered by the medical team that CPR was likely to be futile for Mrs. Smith. Medical futility is often what prompts many professionals to establish end of life wishes and to discuss CPR (Freeman et al, 2014). Futility describes when the goals and aims of the intervention will not be achievable (Trotter, 1999). At the time I was concerned Mr. Smith was not being realistic about Mrs. Smith chance of surviving CPR. Myint et al, (2006) research suggests that tensions can occur when patients and relatives may have unrealistic expectations of

CPR and the outcome, which can create issues in reaching collaborative decisions. Yuen et al, (2011) explained that this could be due to the medias inaccurate portrayal of CPR's success rate.

At the time of the discussion, I was trying to achieve and support patient understanding, although I did not lead the conversation I did feel a part of it and it was evident that Mr. Smith found the conversation to be distressing. Although DNAR can be a distressing conversation I acknowledge that knowing a patient's wishes is imperative for providing good care (LACDP, 2014). Article 8, of The Human Rights Act (1998) states, "the right to respect for private and family life". This act protects patient's rights to be consulted about DNAR orders and to be involved in the decision. However, Griffith (2015, p.498) establishes that denial of futile treatment and that if DNAR discussions may cause severe physical or psychological suffering these factors could potentially "allow scope for intrusion into this right". However, I consider it to be best practice to involve the patient and relatives as often discussions around death and CPR are distressing for most and using this as a reason not to discuss DNAR orders is precarious (Griffith, 2015).

Many patients and relatives may be in denial and find it difficult to discuss DNAR orders. Zimmermann and Rodin (2004) explain that the medicalisation of death has formed a barrier to discussing death and potentially causes denial. Medical advancements and the duty to protect life, health professionals often provide hope of a treatment or test when potentially these may have no benefit in certain circumstances (Zimmermann and Rodin, 2004).

A health professional may have specific medical reasoning behind not attempting resuscitation, which may not be understood by patients and family. Some patients may also fear that they will not receive treatment when a DNAR is in place and this may affect their decision's (Yuen et al, 2011). However, DNAR orders should not impact other aspects of care (Freeman et al, 2014). Conversely, a survey revealed some medicine and surgery residents would withhold blood

products and not prescribe antibiotics (Yuen et al, 2011).Taking this into consideration, I find it difficult to respond to patients concerns on the matter as I cannot account for other professional's actions or omissions that may be involved with their care. For instance if Mrs. Smith was to be hospitalised I would not be involved with her care directly. Whilst discussing the DNAR process with Mr. Smith it was advised that a DNAR would not stop Mrs. Smith from receiving treatment.

Mr. Smith was also made aware that resuscitation could lead to Mrs. Smith experiencing poor quality of life, and the harm might outweigh the possible benefits (Freeman et al, 2014). The human rights act, (1998) states, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". It should be considered that reviving a patient with advanced diseases could cause further complications such as broken ribs, neurological changes and consequently reduce quality of life (Yuen et al, 2011). The human rights act (1998), also states "everyone's right to life shall be protected by law" and it is our legal, professional and ethical responsibility to uphold this. Therefore, DNAR carried out against patient's wishes would contradict this. I acknowledge that my internal thoughts and concerns were about CPR causing harm to Mrs. Smith and that it could prevent a dignified death (Irwin and Ward, 2014). I was aware of these internal factors and did not allow it to effect my actions because I feared the distress it could have caused. I was also concerned if I was basing my emotions on judgement and my own moral view. However, in private discussion with the matron she also shared the same concerns. It was considered not appropriate to discuss our feelings with Mr. Smith as it could be perceived as influencing his decision but to just ensure he was aware of the potential harm. In addition Mrs. Smith was not imminently dying therefore there was scope for further discussions to take place in the future.

Four principles which derive from Beauchamp and Childress's (2001) literature aim to act as a framework to support making ethical decisions. It is important to consider nonmaleficence and beneficence in this scenario. As CPR could potentially cause harm it conflicts with nonmaleficence. However I also consider that putting a DNAR order in place against wishes could also cause harm. Furthermore, in relation to beneficence providing CPR for someone who it is considered to be futile the risks could outweigh the benefits (Beauchamp and Childress, 2001). Applying the principles directly to the scenario has made me consider that my inner thoughts and views were ones that have naturally considered these principles.

The Nursing Midwifery Council (NMC) (2015) provides professional guidance which should be evident in practice. For instance, it is important to not make assumptions and respect choice in order to practice within the professional code of conduct. Regardless, cases exist where health professionals have denied CPR due to their own judgment (Smith and Pitcher, 2015). For instance, individual judgments on patient's age, disability, disease and quality of life have been considered reasons not to commence CPR when a DNAR was not in place (BMA et al, 2014). This is not only unprofessional, unethical and unlawful it could result in great distress for the family and loved ones and professionals have been penalised for such incidents (BMA et al, 2014). For instance the NMC (2013) provides details of a case where a nurse denied CPR on the grounds of best interest even though a DNAR order was not in place which resulted in a "conditions of practice order".

Judgments that are made based on age, disability and / or disease could be considered discriminatory. Myint et al (2006) considers that age is something to take into account when considering DNAR orders. However, guidance concludes age is not a factor to be considered (BMA et al, 2014). I consider that a person at age 80 could have better health than someone of a

much younger age. Basing a DNAR order on a person's age would also conflict with laws protecting people from discrimination, known as The Equality Act, (2010) which protects specific characteristics including age from discrimination. Therefore, if a DNAR was put in place in their best interest it would need to involve relatives, carers, and the wider multidisciplinary team to ensure full consideration has been taken.

The NMC (2015) state, "make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay". Therefore, if a patient had an arrest and a DNAR was not in place it is our duty to commence life saving treatment. In the past I have had concerns about not knowing someone's resuscitation status, as it is our duty of care to establish patient's wishes (LACDP, 2014). I acknowledge if a patient arrested, and there was an element of uncertainty the right action to take would be to commence CPR. However research indicates patients are being resuscitated against their wishes due to lack of communication, and delayed decision making (Yuen et al, 2011). Therefore I recognise that there is a need to provide clear information, education about CPR and its possible outcomes to explore the patients, family feelings and thoughts on the matter (Myint et al, 2006). Furthermore, it was important to revisit this aspect of end of life decisions in the future as his decision may alter over time.

As it is not always possible to accurately predict the circumstances of someone's death, it can be considered that a lack of informed consent exists with DNAR orders (Imhofa et al, 2011). Therefore, it is important to be aware that if a DNAR order is in place a health professional should not rely on this when making a clinical judgment on carrying out CPR (Irwin and Ward, 2014). Instead, the DNAR order should only inform the judgment and then deliberation on whether CPR would be an appropriate treatment at that time should be made (Irwin and Ward, 2014). For instance, if Mr. Smith decided that Mrs. Smith was to have a DNAR order in place for

when her disease caused her health to deteriorate further and a natural death occurred it would be considered informed consent was achieved. However, if Mrs. Smith was subject to an incident that resulted in an unexpected death and there were benefits of carrying out CPR it could be deemed an appropriate action to take (Irwin and Ward, 2014).

Mrs. Smith had been assessed to lack capacity and it was evident during assessments she was unable to understand, retain, weigh up information and communicate her decision due to her dementia (mental capacity act, 2005). Although patients may have been assessed to lack capacity, I consider that trying to involve them in decision making is best practice as it may be possible to provide extra support to make that decision (Irwin and Ward, 2014). However, in this scenario it was not possible due to the more complex nature of the decision. Rustom, et al (2009) concur that capacity is also relative to the enormity of the decision being made, for instance Mrs. Smith may be able to express her wish for food but not have the capacity to make decisions about a DNAR order. The mental capacity act (2005) concludes that a lack of capacity cannot be judged on the person's condition, behaviour, age and appearance. With this in mind I feel it was clear in this scenario that her lack of capacity was not judged on these aspects.

Mrs. Smith was not able to provide consent because she lacked capacity. This caused me to consider whether the decision needed to be escalated to involve more healthcare professionals. As a review carried out by Freeman et al (2014) established that 74% of professionals recommended involving the multidisciplinary team. Mr. Smith could have been basing his decision on the fear of his wife dying. In this case his internal emotions may have been effecting his decision. The mental capacity act (2005), states that a decision made must be in his/her best interest and that the decision made is least restrictive of the person's rights and autonomy. Reid and Jeffrey (2002) consider that relatives may base their decision on their own wishes rather than

the wishes of the patient and that this can cause confliction and feelings of guilt if a DNAR was to go ahead.

I consider that as professionals we are taught and equipped with knowledge on what we should think about when making best interest decisions. The NMC (2015) state, "Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues". Therefore, considering that family may not be equipped with the same knowledge to make a best interest decision it may be useful to guide them and provide education. I consider this could be done by asking questions based on the mental capacity act laws (Mental capacity act, 2005). Questions that I could ask to guide people to make best interest decisions are; is this what Mrs. Smith would want? Has Mrs. Smith ever spoken to you before about her wishes, if so what were they? Does Mrs. Smith have any beliefs or values that may alter her decision (Mental capacity act, 2005)? I consider these could be useful to help families make a decision that will reflect the person's wishes

Conclusion

The laws relative to DNAR decisions which this essay has discussed were from the human rights act (1998) which states, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment" and "everyone's right to life shall be protected by law". I found that these laws raised ethical issues as CPR could result in Mrs. Smith being subject to degrading treatment. However because Mr. Smith made a best interest decision for her to be resuscitated, we have to respect that the right to life is protected by law.

Therefore, it was important to respect his decision made on behalf of his wife. Mr. Smith felt he was acting in the best interest of his wife. However, the essay has also highlighted how relatives

may not make a decision that reflects the patient's wishes (Myint et al, 2006). I consider that using the mental capacity acts (2005) best interest framework may be useful to encourage a patient to make a best interest decision.

Furthermore the essay consulted article 8 of the human rights act (1998) "the right to respect for private and family life". However, cases where DNAR discussion could cause severe psychological and physical harm or if CPR is considered futile it would allow scope to intrude into this law (Griffith, 2015).

As a result of consulting the law, I have realised that it does not always provide a clear solution. Therefore, considering multi factors including ethics and our professional responsibility helped to consider the issues further. For instance considering Beauchamp and Childress (2001) four principles found that CPR could be considered maleficent if it was to cause further harm. However I also considered that the discussion of DNAR also caused harm and escalating it further would have had no benefits at the time. Furthermore, it is our responsibility to respect choice (NMC, 2015). Therefore considering all these aspects, it was felt that respecting Mr. Smith's decision at this time was the right thing to do and we felt it was important to allow Mr. Smith time as there was no imminent need for a decision.

If this situation was to rise again, I feel I would have made the same decision to respect Mr. Smith's wishes. However, I conclude that consulting the law, ethics and professional standards in DNAR decisions is needed to prevent professionals making a decision on judgement and moral view. By doing so I feel it will not only protect you as a professional it will protect your patients from poor practice leading to potential harm.

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